Infectious Disease Epidemiology Section
Office of Public Health, Louisiana Dept of Health & Hospitals
800-256-2748 (24 hr number) – (504) 568-5005
www.oph.dhh.state.la.us

Laboratory Forms

BOURQUE PRINTING, INC. • 1-800-552-4810

WRITE FIRMLY WITH BALL POINT PEN — DO NOT USE FELT PEN OR PENCIL.
DO NOT FOLD OR WRAP AROUND SAMPLE BOTTLE.

LAB 8 (R 10/98)

_____ of _____ Project Code _____

LAB USE ONLY — Lab Sample & Lab Nos ▶ Lab Date and Time Received ▶

LOUISIANA D.H.H. OFFICE OF PUBLIC HEALTH
DIVISION OF LABORATORIES - WATER MICROBIOLOGY
LABORATORY REQUEST AND REPORT FORM

Name of Supply

Address

City | State | Zip | Parish | Collected by

Public Water Supply ID (PWS-ID) (1-7)

Date Collected (8-13) Mo Day Yr

Time Collected (14-17) 24 Hrs

Point of Collection (POC) or POC ID PLEASE PRINT OR TYPE (18-47)

* Note: All repeat drinking water samples should have the lab sample no. of the related positive sample in parenthesis at the end of the POC - eg. (0003456)

TYPE OF SAMPLE

Drinking Water Program

1. Routine
2. Replacement
3. *Repeat - Original Tap
4. *Repeat - Upstream Tap
5. *Repeat - Downstream Tap
6. *Repeat - Additional Tap
7. Investigative
8. Other - Describe above in POC

(48)

Other Potable

1. New Facility(Line,Well,etc.)
2. Well
3. Private Supply
4. Other - describe below in comments

Non Potable

1. Raw Water
2. Surface Water
3. Recreation Water (Bathing Area)
4. Sewage
5. Other - describe below in comments

Comments \ Special Tests

Disinfectant Residual — Free ppm | Total ppm

LABORATORY USE ONLY

MMO-MUG Total Coliform P\A
0. Not Found
1. Present
(49)

MMO-MUG E. Coli P\A
0. Not Found
1. Present
(50)

MMO-MUG Total Coliform MPN MPN / 100 ml	MMO-MUG E. coli MPN MPN / 100 ml
Multiple Tube Fermentation Total Coliform MPN MPN / 100 ml	Multiple Tube Fermentation Fecal Coliform MPN MPN / 100ml
Standard Plate Count / 1ml	Other Tests

Remarks

Date Analyzed:
Time Analyzed:
Analyst:

LABORATORY COPY

Sample No: S 050611

DETACH AND PLACE NUMBERED TAG ON SAMPLE BOTTLE CAP ▷

S 050611

BUDUVUE PRINTING, INC. • 1-800-552-4618

LABORATORY REQUEST AND REPORT FORM LAB 15 (8/91)
NEISSERIA GONORRHOEAE AND CHLAMYDIA TRACHOMATIS
LA. D.H.H. - OFFICE OF PUBLIC HEALTH

WRITE FIRMLY - USE BALL POINT PEN OR TYPE

LAB NO. AND DATE RECEIVED

LAB NO. | DATE RECEIVED

LAB COPY Q 304901

NAME: LAST | FIRST | AGE

ADDRESS | SEX

CITY | PARISH | RACE

DHH # | CLINIC # | SS # | PHONE

PROJECT # | SITE # | DATE SPECIMEN COLLECTED / /

CULTURE FOR NEISSERIA GONORRHOEAE

PREINCUBATED?
[1] YES [2] NO
_____ HRS

PRENATAL
[1] YES [2] NO

P.I.D. SYMPTOMS
[1] YES [2] NO

COLLECTION SITE:
_____ URETHRA
_____ CERVIX / VAGINA
_____ OTHER, SPECIFY

TEST OF CURE
[1] YES [2] NO

LABORATORY RESULTS

[1] CONFIRMED POSITIVE

PRESUMPTIVE POSITIVE [2]

[3] NO NEISSERIA GONORRHOEAE FOUND

UNSATISFACTORY [9]

SENSITIVITY REPORT: ZONE SIZE

CEFTRIAXONE _____
PENICILLIN _____
SPECTINOMYCIN _____
TETRACYCLINE _____
OTHER_____ _____

SMEAR

[1] GRAM NEGATIVE INTRACELLULAR DIPLOCOCCI MORPHOLOGICALLY RESEMBLING GONOCOCCI

GRAM NEGATIVE DIPLOCOCCI MORPHOLOGICALLY RESEMBLING GONOCOCCI [2]

[3] NO GONOCOCCI FOUND

PUS CELLS: NONE___ FEW___ MANY___

UNSATISFACTORY [9]

DNA PROBE

DATE COLLECTED ___/___/___

LAB TEST RESULTS:

NEISSERIA GONORRHOEAE

[1] DETECTED

NOT DETECTED [2]

CHLAMYDIA TRACHOMATIS

[3] DETECTED

NOT DETECTED [4]

[5] UNSATISFACTORY

SEND REPORT TO

DATE REPORTED:

TECH:

LAB CODE:

WRITE FIRMLY - USE BALL POINT PEN OR TYPE

OFFICE OF PUBLIC HEALTH - LABORATORY SERVICES

LAB 15 LAB # _____

FIRMLY USE BALL POINT PEN OR TYPE

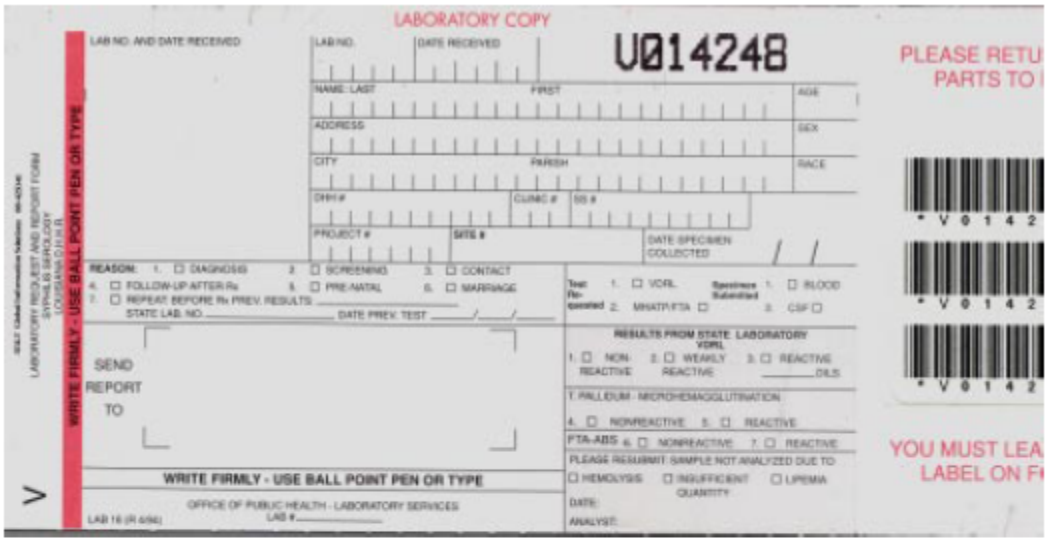
Q 304901

PHYSICIAN - PLEASE NOTE INSTRUCTIONS

Complete CONFIDENTIAL CASE REPORT on reverse side of this form on all persons previously unreported.
REPORT should be completed whether or not clinical diagnosis confirms laboratory findings.

Send REPORT to: LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS OFFICE OF PUBLIC HEALTH
STD Control P.O. Box 60630 New Orleans, LA 70160

Q 304901



LABORATORY COPY

LAB NO. AND DATE RECEIVED

LAB NO. | DATE RECEIVED | V014248

NAME: LAST | FIRST | AGE

ADDRESS | SEX

CITY | PARISH | RACE

DHH # | CLINIC # | SS #

PROJECT # | SITE # | DATE SPECIMEN COLLECTED

WRITE FIRMLY - USE BALL POINT PEN OR TYPE

LABORATORY REQUEST AND REPORT FORM SYPHILIS SEROLOGY

REASON: 1. ☐ DIAGNOSIS 2. ☐ SCREENING 3. ☐ CONTACT
4. ☐ FOLLOW-UP AFTER Rx 5. ☐ PRE-NATAL 6. ☐ MARRIAGE
7. ☐ REPEAT BEFORE Rx PREV. RESULTS: _____
STATE LAB. NO. _____ DATE PREV. TEST ___/___/___

Test Re-quested: 1. ☐ VDRL 2. MHATP/FTA ☐ 3. ☐ CSF ☐
Specimen Submitted: 1. ☐ BLOOD

SEND REPORT TO

RESULTS FROM STATE LABORATORY
VDRL
1. ☐ NON-REACTIVE 2. ☐ WEAKLY REACTIVE 3. ☐ REACTIVE _____ DILS
T. PALLIDUM - MICROHEMAGGLUTINATION
4. ☐ NONREACTIVE 5. ☐ REACTIVE
FTA-ABS 6. ☐ NONREACTIVE 7. ☐ REACTIVE
PLEASE RESUBMIT SAMPLE NOT ANALYZED DUE TO:
☐ HEMOLYSIS ☐ INSUFFICIENT QUANTITY ☐ LIPEMIA
DATE:
ANALYST:

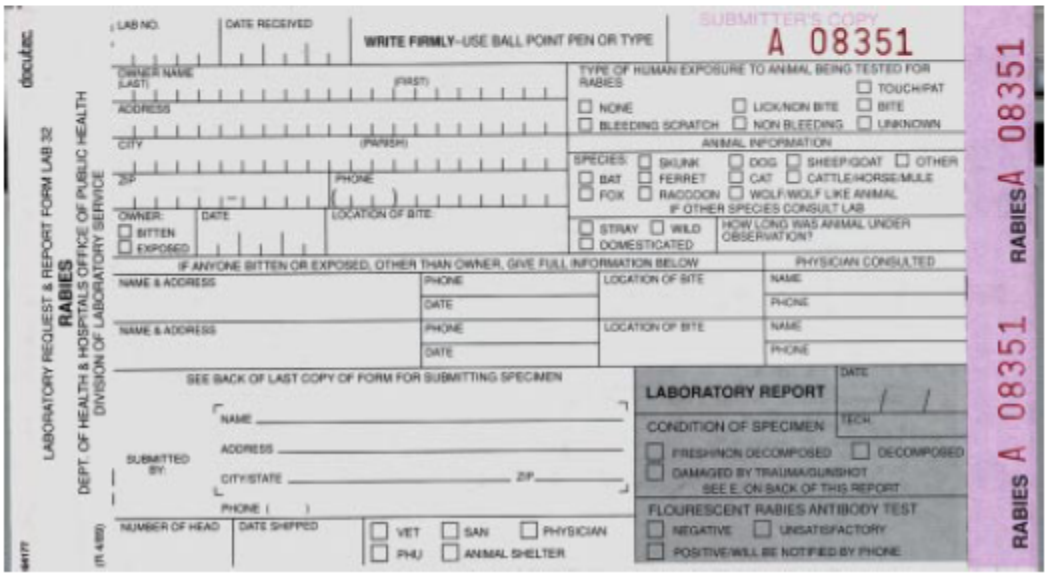
WRITE FIRMLY - USE BALL POINT PEN OR TYPE

OFFICE OF PUBLIC HEALTH - LABORATORY SERVICES
LAB #_____
LAB 16 (R 6/94)

PLEASE RETU
PARTS TO

* V 0 1 4 2
* V 0 1 4 2
* V 0 1 4 2

YOU MUST LEA
LABEL ON F



SUBMITTER'S COPY

LAB NO. | DATE RECEIVED | WRITE FIRMLY–USE BALL POINT PEN OR TYPE | A 08351

OWNER NAME (LAST) (FIRST)

ADDRESS

CITY (PARISH)

ZIP | PHONE

OWNER: ☐ BITTEN ☐ EXPOSED | DATE | LOCATION OF BITE

TYPE OF HUMAN EXPOSURE TO ANIMAL BEING TESTED FOR RABIES
☐ NONE ☐ TOUCH/PAT ☐ LICK/NON BITE ☐ BITE ☐ BLEEDING SCRATCH ☐ NON BLEEDING ☐ UNKNOWN

ANIMAL INFORMATION
SPECIES: ☐ SKUNK ☐ DOG ☐ SHEEP/GOAT ☐ OTHER ☐ BAT ☐ FERRET ☐ CAT ☐ CATTLE/HORSE/MULE ☐ FOX ☐ RACCOON ☐ WOLF/WOLF LIKE ANIMAL
IF OTHER SPECIES CONSULT LAB
☐ STRAY ☐ WILD ☐ DOMESTICATED
HOW LONG WAS ANIMAL UNDER OBSERVATION?

IF ANYONE BITTEN OR EXPOSED, OTHER THAN OWNER, GIVE FULL INFORMATION BELOW

NAME & ADDRESS	PHONE / DATE	LOCATION OF BITE	PHYSICIAN CONSULTED: NAME / PHONE
NAME & ADDRESS	PHONE / DATE	LOCATION OF BITE	NAME / PHONE

SEE BACK OF LAST COPY OF FORM FOR SUBMITTING SPECIMEN

SUBMITTED BY:
NAME _____
ADDRESS _____
CITY/STATE _____ ZIP _____
PHONE ( )

NUMBER OF HEAD | DATE SHIPPED
☐ VET ☐ SAN ☐ PHYSICIAN ☐ PHU ☐ ANIMAL SHELTER

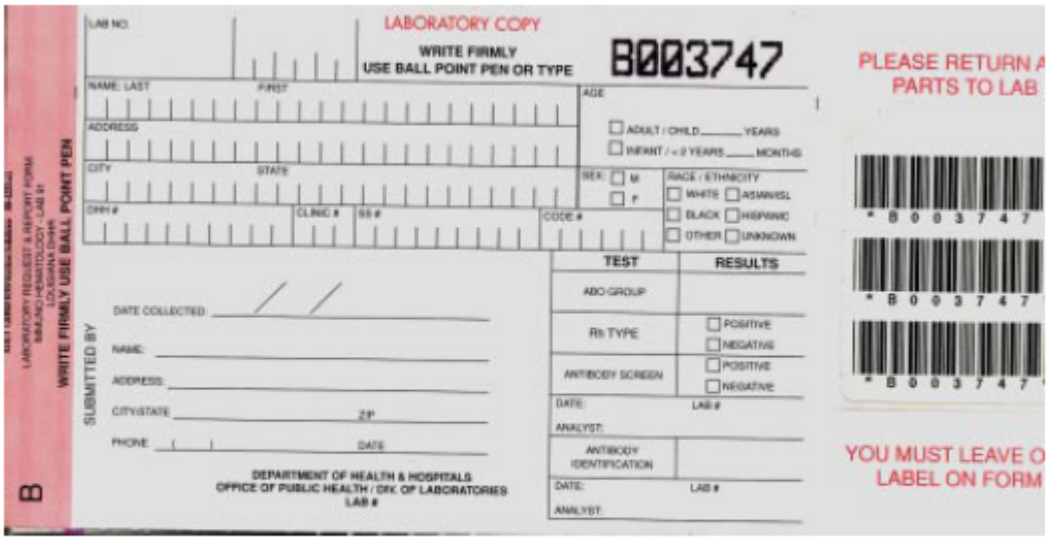
LABORATORY REPORT
DATE ___/___/___
TECH
CONDITION OF SPECIMEN
☐ FRESH/NON DECOMPOSED ☐ DECOMPOSED
☐ DAMAGED BY TRAUMA/GUNSHOT
SEE E. ON BACK OF THIS REPORT

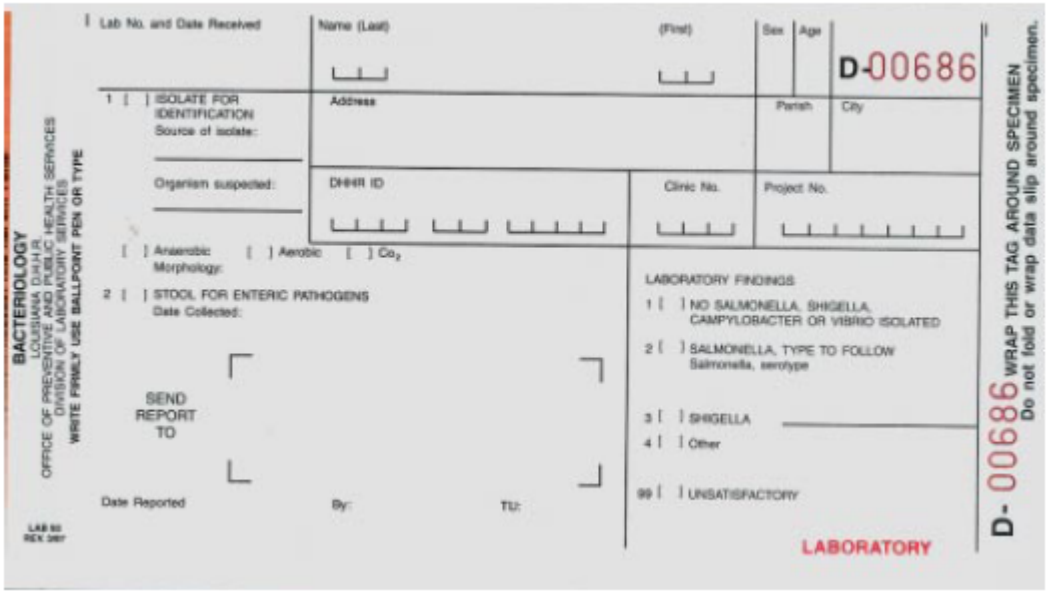
FLOURESCENT RABIES ANTIBODY TEST
☐ NEGATIVE ☐ UNSATISFACTORY
☐ POSITIVE/WILL BE NOTIFIED BY PHONE

LABORATORY REQUEST & REPORT FORM LAB 32
RABIES
DEPT. OF HEALTH & HOSPITALS OFFICE OF PUBLIC HEALTH
DIVISION OF LABORATORY SERVICE
(R 4/89)

RABIES A 08351

RABIES A 08351


LABORATORY COPY
WRITE FIRMLY
USE BALL POINT PEN OR TYPE
B003747
LAB NO.
NAME: LAST
FIRST
ADDRESS
CITY
STATE
DHH #
CLINIC #
SS #
CODE #
AGE
ADULT / CHILD _____ YEARS
INFANT / < 2 YEARS _____ MONTHS
SEX: M F
RACE / ETHNICITY
WHITE ASIAN/ISL
BLACK HISPANIC
OTHER UNKNOWN
TEST
RESULTS
ABO GROUP
Rh TYPE
POSITIVE
NEGATIVE
ANTIBODY SCREEN
POSITIVE
NEGATIVE
DATE:
LAB #
ANALYST:
ANTIBODY IDENTIFICATION
DATE:
LAB #
ANALYST:
SUBMITTED BY
DATE COLLECTED:
NAME:
ADDRESS:
CITY/STATE
ZIP
PHONE
DATE
DEPARTMENT OF HEALTH & HOSPITALS
OFFICE OF PUBLIC HEALTH / DIV. OF LABORATORIES
LAB #
WRITE FIRMLY USE BALL POINT PEN
B
PLEASE RETURN A
PARTS TO LAB
* B 0 0 3 7 4 7
* B 0 0 3 7 4 7
* B 0 0 3 7 4 7
YOU MUST LEAVE O
LABEL ON FORM


BACTERIOLOGY
OFFICE OF PREVENTIVE AND PERINATAL HEALTH SERVICES
DIVISION OF LABORATORY SERVICES
WRITE FIRMLY USE BALLPOINT PEN OR TYPE
Lab No. and Date Received
Name (Last)
(First)
Sex
Age
D-00686
1 [ ] ISOLATE FOR IDENTIFICATION
Source of isolate:
Address
Parish
City
Organism suspected:
DHHR ID
Clinic No.
Project No.
[ ] Anaerobic [ ] Aerobic [ ] Co_2
Morphology:
2 [ ] STOOL FOR ENTERIC PATHOGENS
Date Collected:
SEND REPORT TO
Date Reported
By:
TU:
LABORATORY FINDINGS
1 [ ] NO SALMONELLA, SHIGELLA, CAMPYLOBACTER OR VIBRIO ISOLATED
2 [ ] SALMONELLA, TYPE TO FOLLOW
Salmonella, serotype
3 [ ] SHIGELLA
4 [ ] Other
99 [ ] UNSATISFACTORY
LABORATORY
D-00686 WRAP THIS TAG AROUND SPECIMEN
Do not fold or wrap data slip around specimen.

LAB 96 (R 2/96)

LAB REQUEST & REPORT FORM

IMMUNOLOGY

WRITE FIRMLY - USE BALL POINT PEN OR TYPE

LOUISIANA D.H.H.
OFFICE OF PUBLIC HEALTH
DIVISION OF LABORATORY SERVICES

LAB NO. AND DATE RECEIVED	Name (Last)	(First)	Sex Age	I 45916
	Address	City	Parish State	
TESTING LAB NO. _____	OPH ID	Clinic	REP. CAT. #	PLEASE CALL THE LAB IF YOU HAVE ANY QUESTIONS.
MEDICAID #	SSN			

SEND REPORT TO

SPECIMEN ☐ HUMAN ☐ ANIMAL _____

☐ ACUTE ☐ CONVALESCENT ☐ FOLLOW-UP ☐ PRENATAL
☐ MOTHER ☐ CHILD SUBMIT ONE DATA SLIP PER SPECIMEN.

SUBMIT A SERUM OR RED TOP TUBE ONLY

HISTORY
DATE OF ONSET _____ DATE COLLECTED _____
ACUTE SERUM: (S-1) _____ CONV. SERUM (S-2) _____
CLINICAL DIAGNOSIS: _____

☐ RESPIRATORY PANEL
- ☐ RSV ABY
- ☐ ADENOVIRUS ABY
- ☐ MYCO PNEUMONIAE ABY
- ☐ INF A ABY
- ☐ INF B ABY
- ☐ PARA INF 1 ABY
- ☐ PARA INF 2 ABY
- ☐ PARA INF 3 ABY

☐ HERPES PANEL
- ☐ ☐ HERPES I IgG
  ☐ HERPES II IgG
- ☐ ☐ HE GP IgG
  ☐ HE GP IgM

☐ RICKETTSIA PANEL
- ☐ RICK PANEL IgG
- ☐ RICK PANEL IgM
- ☐ TYPHUS GP ABY
- ☐ R TYPHI IgG ABY
- ☐ R TYPHI IgM ABY
- ☐ R RICKETTSII IgG ABY
- ☐ R RICKETTSII IgM ABY
- ☐ Q FEVER PHASE 1 IgG
- ☐ Q FEVER PHASE 1 IgM
- ☐ Q FEVER PHASE 2 IgG
- ☐ Q FEVER PHASE 2 IgM

☐ LYMES DISEASE PANEL
- ☐ LYMES TOTAL ABY
- ☐ LYMES IgG ABY
- ☐ LYMES IgM ABY

☐ TORCH PANEL
- ☐ TORCH PANEL IgG
- ☐ TORCH PANEL IgM
- ☐ TOXO IgG _____
- ☐ TOXO IgM _____
- ☐ RUBELLA IgG _____
- ☐ RUBELLA IgM _____
- ☐ CMV IgG _____
- ☐ CMV IgM _____
- ☐ HERPES GR IgG _____
- ☐ HERPES GR IgM _____

☐ EXANTHEM PANEL
- ☐ EXANTHEM PANEL IgG
- ☐ EXANTHEM PANEL IgM
- ☐ RUBELLA IgG
- ☐ RUBELLA IgM
- ☐ MEASLES IgG
- ☐ MEASLES IgM
- ☐ VARICELLA IgG
- ☐ VARICELLA IgM

☐ CDC NEEDS HISTORY
- ☐ CDC _____

☐ ARBOVIRUS PANEL
- ☐ ARBOVIRUS PANEL IgG
- ☐ ARBOVIRUS PANEL IgM
- ☐ ST. LOUIS ENCEPH IgG
- ☐ ST. LOUIS ENCEPH IgM
- ☐ EASTERN ENCEPH IgG
- ☐ EASTERN ENCEPH IgM
- ☐ WEE ENCEPH IgG
- ☐ WEE ENCEPH IgM
- ☐ CALIF ENCEPH IgG
- ☐ CALIF ENCEPH IgM
- ☐ DENGUE ABY

☐ MISC. ASSAYS
- ☐ B. PERTUSSIS
- ☐ B. PARAPERTUSSIS
- ☐ LEPTOSPIRAL ABY
- ☐ MUMPS ABY
- ☐ POLIO VIRUS IgG ABY (GP 1, 2, 3)
- ☐ CHLAMYDIA ABY
- ☐ LEGIONELLA GP ABY
- ☐ HCG
- ☐ OTHER _____

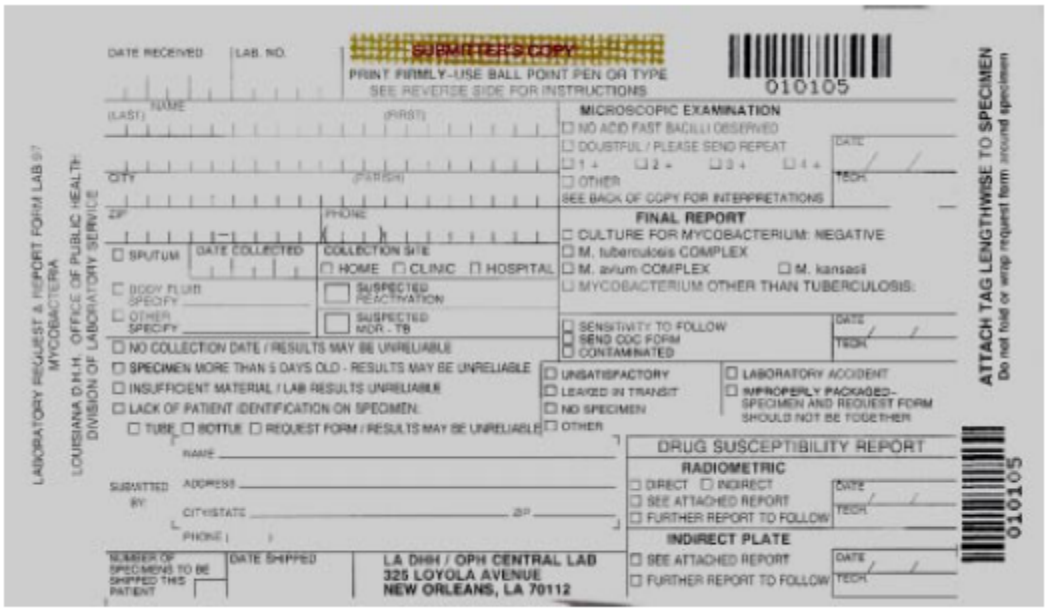
UNSATISFACTORY _____

DATE/TECH _____

DATE/SUP _____

PLEASE CHECK BOX FOR SINGLE TEST OR PANEL PROFILE NEEDED.

SUBMITTER'S COPY


LABORATORY REQUEST & REPORT FORM LAB 97
MYCOBACTERIA
LOUISIANA D.H.H. OFFICE OF PUBLIC HEALTH
DIVISION OF LABORATORY SERVICE
DATE RECEIVED
LAB. NO.
SUBMITTER'S COPY
PRINT FIRMLY-USE BALL POINT PEN OR TYPE
SEE REVERSE SIDE FOR INSTRUCTIONS
010105
(LAST)
(FIRST)
CITY
(PARISH)
ZIP
PHONE
SPUTUM
DATE COLLECTED
COLLECTION SITE
HOME
CLINIC
HOSPITAL
BODY FLUID
SPECIFY
OTHER
SPECIFY
SUSPECTED REACTIVATION
SUSPECTED MDR - TB
NO COLLECTION DATE / RESULTS MAY BE UNRELIABLE
SPECIMEN MORE THAN 5 DAYS OLD - RESULTS MAY BE UNRELIABLE
INSUFFICIENT MATERIAL / LAB RESULTS UNRELIABLE
LACK OF PATIENT IDENTIFICATION ON SPECIMEN:
TUBE
BOTTLE
REQUEST FORM / RESULTS MAY BE UNRELIABLE
SUBMITTED BY:
NAME
ADDRESS
CITY/STATE
ZIP
PHONE ( )
NUMBER OF SPECIMENS TO BE SHIPPED THIS PATIENT
DATE SHIPPED
LA DHH / OPH CENTRAL LAB
325 LOYOLA AVENUE
NEW ORLEANS, LA 70112
MICROSCOPIC EXAMINATION
NO ACID FAST BACILLI OBSERVED
DOUBTFUL / PLEASE SEND REPEAT
1 +
2 +
3 +
4 +
OTHER
SEE BACK OF COPY FOR INTERPRETATIONS
DATE
TECH
FINAL REPORT
CULTURE FOR MYCOBACTERIUM: NEGATIVE
M. tuberculosis COMPLEX
M. avium COMPLEX
M. kansasii
MYCOBACTERIUM OTHER THAN TUBERCULOSIS:
SENSITIVITY TO FOLLOW
SEND CDC FORM
CONTAMINATED
DATE
TECH
UNSATISFACTORY
LEAKED IN TRANSIT
NO SPECIMEN
OTHER
LABORATORY ACCIDENT
IMPROPERLY PACKAGED- SPECIMEN AND REQUEST FORM SHOULD NOT BE TOGETHER
DRUG SUSCEPTIBILITY REPORT
RADIOMETRIC
DIRECT
INDIRECT
SEE ATTACHED REPORT
FURTHER REPORT TO FOLLOW
DATE
TECH
INDIRECT PLATE
SEE ATTACHED REPORT
FURTHER REPORT TO FOLLOW
DATE
TECH
ATTACH TAG LENGTHWISE TO SPECIMEN
Do not fold or wrap request form around specimen
010105

Bosque Printing, Inc.

LABORATORY REQUEST AND REPORT FORM

FOOD & DRUG (BACTERIOLOGY-CHEMISTRY-MYCOLOGY)

LOUISIANA D.H.H.
OFFICE OF PUBLICE HEALTH
Division of Laboratory Services

Program Code _____

Sample No.: J 001701

Lab Number:

Date Received:

Sample of (Product) | Label (Name of Prod., Brand, Wholesale Nos., Etc.) | Code

Amount of Sample | Amount of Material Left

Manufactured or Packed by (Leave Blank if Unknown) | Address

Received by Dealer from | Address

Dealer or Point of Collection | Address

Date Collected | Time ☐ AM ☐ PM | City and Parish | Length of Time in Stock

Reason for Collection | Were Goods Seized? ☐ Yes ☐ No | Amount Seized

Remarks | Signature of Sanitarian

Signature of Owner or Agent | Office Address of Parish Health Unit

Tests Requested

FOR LABORATORY USE ONLY

MEMBRANE FILTER TEST
COLIFORMS PER 100 ML | CONFLUENT ☐ | TNTC ☐ | WITH COLIFORMS ☐

MULTIPLE TUBE TEST
NO. OF POSITIVE TUBES

Fecal Coliform Test MPN Per 100 ML | Coliform MPN Test MPN Per 100 ML | Standard Plate Count/

E. coli Test MPN Per 100 ML | P - A Test Coliforms Per 100 ML

NEGATIVE ☐ POSITIVE ☐

Direct Plate Count:

Staph _____ (Negative) Staph aureus, coagulase positive _____

Salmonella:

☐ No Salmonella isolated ☐ Other:

Vibrio:

☐ Vibrio parahaemolyticus _____ /gm
☐ Vibrio cholerae _____ /gm
☐ Vibrio fluvialis _____ /gm
☐ Vibrio vulnificus _____ /gm

Other:

ANALYST: DATE & TIME ANALYZED:

FOR FOOD & DRUG USE ONLY

( ) Sample meets requirements.

( ) Sample does not meet requirements; collect on additional sample consisting of _____

Submit to the _____ Laboratory for _____

SANITARIAN'S ENDORSEMENT

LAB

Detach and Place Numbered Tag on Sample

J 001701 J 001701 J 00170

LAB COPY

LAB 100 FORM - LABORATORY REQUEST AND REPORT FORM

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF PUBLIC HEALTH - DIVISION OF LABORATORIES

D000005

USE PEN - GREY AREAS MUST BE COMPLETED

LAB NO.
DATE RECEIVED

CLIENT CODE #

MEDICAID # (If unavailable use SSN)

LAST NAME:

FIRST NAME:

DATE SPECIMEN COLLECTED

CITY

PARISH FIPS** STATE FIPS** ZIP CODE

**SEE BACK OF PINK COPY

TYPE OF TEST
- ☐ ANONYMOUS
- ☐ CONFIDENTIAL

SEX:
- 1 MALE
- 2 FEMALE

AGE

DATE OF BIRTH

RACE/ETHNICITY:
- 1 White, Non-Hispanic
- 2 Black, Non-Hispanic
- 3 Hispanic
- 4 Asian/Pacific Islander
- 5 Amer. Indian/AK Native
- 6 Other
- 7 Undetermined

USE PASSPORT LABEL if available

SITE #

SITE TYPE* *SEE BACK

PRETEST CNSLOR #

REPT CATEGORY #

SEND REPORT TO: (Submitter's Address)

PHONE #_____

REASON FOR VISIT
(Mark all that apply)
- 1 Symptomatic HIV/AIDS
- 2 Client Referral
- 3 Provider Referral
- 4 STD Related
- 5 Drug Treatment Related
- 6 Family Planning Related
- 7 Prenatal/OB Related
- 8 TB Related
- 9 Court Ordered
- 10 Immigration/Travel Req.
- 11 Occupational Exposure
- 12 Requesting HIV Test
- 13 Other

RISK INFORMATION
(Mark all that apply)

CLIENT HAS:	Last 12 mos.	Since 1978
Sex with Male	12	13
Sex with Female	14	15
Injected Drugs	16	17
Occupational Expos	18	19
None of the Above		20

OTHER FACTORS CLIENT HAS:		
STD Diagnosis	21	22
Drug Use		
Heroin/Opiates	23	24
Cocaine/Crack	25	26
Exchg Sex for Drugs/$$	27	28

RISK OF PARTNER(S):		
HIV Positive	31	32
Male to Male Sex	33	34
Injection Drug Use	35	36

OTHER RISK BEHAVIOR(S):

Sex Partners Last 12 months

How Often Does Client Use Condoms? (1-Always, 2-Usually, 3-Sometimes, 4-Never)

Did Client Use Condoms Last Time He/She Had Sex (check one): Yes 11 / No 12

TEST REQUESTED		TYPE OF SPECIMEN:	PREVIOUSLY TESTED?
	PRIOR APPROVAL ONLY		
1 HIV-1/HIV-2	4 CD4/CD8	1 SERUM	1 NO
2 HIV-1	5 VIRAL LOAD	2 PLASMA	2 YES, NEGATIVE
3 HIV-2	6 HIV-1 RNA	3 BLOOD	3 YES, POSITIVE
	7 OTHER	4 ORAL FLUID	4 YES, INCONCLUSIVE
		5 URINE	5 YES, UNKOWN

☐ RETEST (within last 3 months)

PREVIOUS ID #_____

DATE OF MOST RECENT TEST

_____/_____/_____

FOR LABORATORY USE ONLY

HIV-1/HIV-2 EIA
☐ REACTIVE
NON-REACTIVE 0

ANALYST:_____ LAB #:_____

DATE:_____

HIV-1 EIA
☐ REACTIVE
NON-REACTIVE 0

ANALYST:_____ LAB #:_____

DATE:_____

HIV-2 EIA
☐ REACTIVE
NON-REACTIVE 0

ANALYST:_____ LAB #:_____

DATE:_____

HIV-1 WESTERN BLOT
1 REACTIVE
NON-REACTIVE 2
INDETERMINATE 3

ANALYST:_____ LAB #:_____

DATE:_____

UNSATISFACTORY DUE TO:
1 HEMOLYSIS 2 LIPEMIA
3 CONTAMINATION
4 INSUFFICIENT QUANTITY
5 NO SPECIMEN RECEIVED

DATE:_____ LAB #:_____

HIV-2 WESTERN BLOT
1 REACTIVE
NON-REACTIVE 2
INDETERMINATE 3

ANALYST:_____ LAB #:_____

DATE:_____

LABORATORY REPORT

HIV-1 REPORT
☐ NEGATIVE ☐ POSITIVE
☐ INCONCLUSIVE
(A FOLLOWUP SPECIMEN IS RECOMMENDED)
DATE:_____ LAB#_____
REPORTED BY:_____
REVIEWED BY:_____

HIV-1 VIRAL LOAD
_____ COPIES/ML

<LOWER LIMIT ☐
DATE ANALYZED:_____
DATE REPORTED:_____
REVIEWED BY:_____

T CELL SUBSETS
CD4/CD8
CD4_____
CD8_____
RATIO:_____
DATE ANALYZED:_____
DATE REPORTED:_____
REVIEWED BY:_____

HIV-2 REPORT
☐ NEGATIVE ☐ POSITIVE
☐ INCONCLUSIVE
(A FOLLOWUP SPECIMEN IS RECOMMENDED)
DATE:_____ LAB#_____
REPORTED BY:_____
REVIEWED BY:_____